STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
,	G. GG		A. BUILDING:	<del></del>		
		FCL001184	B. WING		12/0	8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIA1 F	AMILY CARE HOME		NDLY ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	The Adult Care Lice initial survey on 12/	ensure Section conducted an 08/21.				
C 145	5 10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall:		C 145			
		Intiated findings listed on the lth Care Personnel Registry 31E-256;				
	This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 3 sampled staff (A and C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to hire.					
	The findings are:					
	Review of the facilit license was effective	ty's license revealed the re on 06/08/21.				
	Personal Care Aide revealed:	a's, Medication Aide (MA)/ e (PCA) personnel record				
	-There was docume	e of hire documented. entation a HCPR check was A on 07/18/21 with no gs.				
		ne interview with Staff A on was unsuccessful.				
	Interview with the A 6:43pm revealed:	dministrator on 09/08/21 at				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/08/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELIA 1 F	AMILY CARE HOME		NDLY ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 145	-Staff A's date of hir-Staff A did not star October 2021He was responsible checks on new emparter and the usually comple 2. Review of Staff Control Personal Care Aider revealed: -There was no date and the and th	re was 05/01/21. It working at the facility until the for performing HCPR bloyees. Ited HCPR checks upon hire C's, Medication Aide (MA)/ (PCA) personnel record of hire documented. Immentation a HCPR check Staff C. If with Staff C on 12/08/21 at Inster facility, but she filled in at times. If illing in at the facility on 11/22/21, and on the weekend Inber when she filled in at the ember and December 2021. If a HCPR check was pon hire. It was June 2021. In another one of his facilities, but acility in June 2021 and a few	C 145			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/0	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
ELIA1 F	FAMILY CARE HOME		NDLY ROAD	247		
(V4) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	STON, NC 27	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 147	Continued From page 2		C 147			
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications		C 147			
	<ul><li>(a) Each staff pers shall:</li><li>(7) have a criminal accordance with G. 131D-40;</li><li>This Rule is not me Based on record refacility failed to ens</li></ul>	views and interviews, the ure 1 of 3 sampled staff (A) minal background check				
	The findings are:					
	Review of the facilit	ry's license revealed the re on 06/08/21.				
	Review of Staff A's, Medication Aide (MA)/Personal Care Aide (PCA), personnel record revealed: -There was no date of hire documentedThere was documentation of a criminal background check completed on 11/18/20There was no documentation of a criminal background check on or after 06/08/21					
		ne interview with Staff A on was unsuccessful.				
	6:43pm revealed: -He was responsibl background checks -Staff A had a crimi	dministrator on 12/08/21 at e for ensuring criminal s were completed upon hire. nal background check ner one of his facilities but not ty.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL001184	B. WING		12/0	8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ELIA 1 F	AMILY CARE HOME		NDLY ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 147	-He thought he coul background check facility.	Id use the criminal from the other facility for this did medication and provided	C 147			
C 246	10A NCAC 13G .0902(b) Health Care  10A NCAC 13G .0902 Health Care  (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 sampled residents related to a missed wellness appointment and a pulmonology appointment (Resident #1).		C 246			
	11/09/21 revealed of pneumonia, chronic disease, and respira Review of Resident	obstructive pulmonary				
	primary care provid at 11:33am revealed -Resident #1 had an visit on today, 12/08 show."	n appointment for a wellness 3/21 at 10:30am and was a "no cility called to cancel or				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		FCL001184	B. WING		12/0	8/2021
	PROVIDER OR SUPPLIER FAMILY CARE HOME	206 FRIEN	DRESS, CITY, S NDLY ROAD TON, NC 27	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 246	-The PCP's office s appointment for Re staff of the appointr -The appointment with scheduled for 12/07 Interview with a rec pulmonologist's office revealed: -Resident #1 had appulmonologist for a 9:15amResident #1 was cone called to cance pulmonologist appoof the appointment.  Interview with Resident -She did not know stoday, 12/08/21, with -She knew she had dentist on today, but because she was nor she did not know stoday, 12/08/21, with -She did not know stoday, 12/08/21, with -She did not know stoday, 12/08/21, with -She did not know stoday and the pulmonologist of -There was no reas gone to the appoint -Her breathing was yesterday (12/07/21)  A second interview at 6:29pm revealed -Her PCP referred because she had be being admitted to the to make sure every breathing.	cheduled a pulmonology sident #1 and informed facility ment. with the pulmonologist was 7/21 at 9:15am.  eptionist at Resident #1's ce on 12/08/21 at 11:48am in appointment with the in initial visit on 12/07/21 at considered a "no show" as no of or reschedule the continuent until around the time dent #1 on 12/08/21 at she had an appointment on the her PCP. In an appointment with the sit she did not choose to go of feeling well. She had an appointment with the pulmonologist. Toon why she could not have ment with the pulmonologist. Tokay" today and on 1).  with Resident #1 on 12/08/21: There to a pulmonologist een in the hospital prior to the facility and the PCP wanted thing was "okay" with her a year since she was last seen	C 246			

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DIVISION	Of Fleatill Service IN	guiation				1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		FCL001184	B. WING		12/0	8/2021
NAME OF	DRU/IDEB UD STIDDITED		DRESS CITY O	STATE, ZIP CODE		
INAIVIE UF I	PROVIDER OR SUPPLIER			DIALL, ZIF CODE		
ELIA 1 F	AMILY CARE HOME		IDLY ROAD			
	The state of the s	BURLING	TON, NC 27	217		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGOLATORT OR E	OCIDENTIF FING IN CHWATION)	TAG	DEFICIENCY)	MAIL	57.11.2
C 246	Continued From pa	ge 5	C 246			
	Telephone interview	wwith Resident #1's PCP on				
	12/08/21 at 2:33pm					
		monologist referral dated				
		ve been dated 11/23/21 as				
		sit she had with Resident #1.				
		een a pulmonologist previously				
		netic traits which placed her at				
		monary complications.				
	-She thought it would be best for Resident #1 to					
	be monitored by a p					
		n appointment with her today,				
		care wellness visit, but she				
		d this was a little concerning				
	to her.	g				
		dministrator on 12/08/21 at				
	12:04pm revealed:					
		e of residents' appointments				
		em to medical appointments.				
	-Resident #1 had a					
		12/08/21 with her PCP, but				
	her appointments w	ere double booked as she				
		tment with her dentist today.				
		dental appointment for				
	Resident #1 on 12/0					
		did not call him back until				
		12/07/21 with the appointment				
	for 12/08/21 at 11:1					
		m she preferred to go to the				
		because she had broken a				
	tooth.					
		hy he did not cancel or				
		nt #1's wellness appointment.				
		#1 had a pulmonologist				
		sterday, on 12/07/21.				
		ncy with another resident in				
		acilities, so he could not take				
	Resident #1 to the	pulmonologist appointment.				
		else to take Resident #1 to				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL001184	B. WING	B. WING		12/08/2021	
	PROVIDER OR SUPPLIER	206 FRIEN	DRESS, CITY, S NDLY ROAD TON, NC 27	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 246	the pulmonologist, l	appointment. esident #1's appointment with out he did not do so until he appointment because of	C 246				
C 288	10A NCAC 13G .0905(a) Activities Program  10A NCAC 13G .0905 Activities Program  (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.		C 288				
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement a program of activities to promote the residents' active involvement with each other and the community.  The findings are:						
	times between 10:1	facility on 12/08/21 at various 5am to 1:15am and 2:30pm to activities were offered to the					
	2021 revealed: -The activity calend posted on the wall the street of the wall the street of the week in December scheduled dailyActivities for the mincluded crafts, sing bee, church, walk a	ty calendar for December ar for December 2021 was behind the dining table. Its of activities listed for each 2021 and there was an activity onth of December 2021 g-a-long, drawing, spelling round the block, toss ball, tune, devotion-singing, movie					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/08/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 .2.0	<u> </u>
ELIA1 F	AMILY CARE HOME		IDLY ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 288	tv church, sharing he the month, arts and chess, and playing -The activity for 12/block and was sche 11:00am  Observation of the various times betwee revealed: -There was a reside appointment and reservisitThere was another at the store and reterment and reservisitThere was one reservisit.	I game, story time, movie quiz, healthy tips, birthday party for I crafts, board games, art day, cards.  08/21 was walk around the eduled from 10:00am until residents on 12/08/21 at een 10:15am and 7:00pm ent laying on the couch in the ent who left the facility for an eturned.  Tresident who was dropped off urned.  Sident visiting other residents in sidents sitting in the living ident on 12/08/21 at 10:24am exities offered in the facility, but articipate in activities.  The gan outing for the two of an activities calendar.  Cond resident on 12/08/21 at 10:20 at 20 activities offered to residents itted to the facility about a sitted to the facility about a	C 288			
	month agoShe wanted to do a	activities and thought volleyball tivities would be fun.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
,	o. oo.u.20o		A. BUILDING:			
		FCL001184	B. WING		12/0	8/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ELIA 1 F	AMILY CARE HOME		NDLY ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 288	Continued From pa	ige 8	C 288			
	10:33am revealed: -There were no act -He would participa -He and another re the bus to a local re  Interview with the M Care Aide (PCA) or -The staff on duty wactivities during the -She started workin 2021 and had not s November 2021 or -She had not done residents since she -She usually sat wit living room and war residents preferred  Interview with the A 6:43pm revealed: -The MA/PCAs wer activities with the re -For a long time, th facilityHe knew residents opportunity to partic dailyStaff had not been residents recently be	ng in the facility in November seen an activity calendar for December 2021.  any activities with the started working at the facility. It some of the residents in the tched television and other to stay in their rooms.  Administrator on 12/08/21 at re responsible for doing esidents.  ere was only 1 resident in the cipate in 14 hours of activities a conducting activities with because staff had been days and taking care of the				
C992	G.S. § 131D-45 G.S and screening for	S. § 131D-45. Examination	C992			
	G.S. § 131D-45. Ex	camination and screening for				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING		12/0	8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ELIA 1 I	FAMILY CARE HOME		NDLY ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C992	Continued From pa	ge 9	C992			
	the presence of cor	ntrolled substances required in ployment in adult care				
	licensed under this conditioned on the a examination and so substances. The exbe conducted in acc Chapter 95 of the Corocedure that utilized may be used for the of applicants and must the results of the applicants and must the applicant unless the adult care home applicant's prescribe controlled substance examination and so physician to treat the psychological condiphysician shall inclusubstance, the present and the condition for prescribed. If the reemployee's examination and so care home may requand screening to vere examination and so care in the presence of a correct the condition and so care than a screening to vere examination and so controlled substance controlled substance and substance controlled substance.	reening is prescribed by that the applicant's medical or a tion. The verification from the side the name of the controlled scribed dosage and frequency, or which the substance is sault of an applicant's or ation and screening indicates controlled substance, the adult uire a second examination erify the results of the prior creening.				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		FCL001184	B. WING		12/0	8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			NDLY ROAD			
ELIA 1 F	AMILY CARE HOME		TON, NC 27			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
C992	Continued From page 10		C992			
	The findings are:					
	Review of the facilit	y's license revealed the				
	license was effectiv	e on 06/08/21.				
	1. Review of Staff A					
	(MA)/Personal Care Aide (PCA), personnel record revealed: -There was no hire date listed for Staff A.					
		cate dated 05/01/21 for Staff A				
		uccessfully passed a random				
	drug test.					
		umentation of the test batch				
	number or test resu	ılts.				
		e interview with Staff A on				
	12/08/21 at 5:44pm	was unsuccessful.				
	Interview with the A	dministrator on 12/08/21 at				
		taff A's hire date was 05/01/21.				
	pm.rovodiod o	ian, 10 mme date mae 00,0 1,2 n				
	Refer to interview w	vith the Administrator on				
	12/08/21 at 4:41pm					
	2. Review of Staff E	•				
		e Aide (PCA), personnel				
	record revealed:	date listed for Staff B.				
		cate dated 11/10/21/21 for				
		g she successfully passed a				
	random drug test.	g chie duddeddidily padded a				
		umentation of the test batch				
	number or test resu					
		B on 12/08/21 at 5:09pm				
		nbered doing a drug test at				
		t 2021, but she had not done a				
		started working at the facility				
	on 11/26/21.					1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		FCL001184	B. WING		12/0	8/2021
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ELIA 1 F	FAMILY CARE HOME	BURLING	TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C992	Continued From pa	ge 11	C992			
		dministrator on 12/08/21 at taff B's hire date was 11/26/21.				
	Refer to interview with the Administrator on 12/08/21 at 4:41pm.					
	(MA)/Personal Care record revealed: -There was no hire	C's, Medication Aide e Aide (PCA), personnel date listed for Staff C. umentation of a drug				
	5:46pm revealed: -She worked at a si the facility about 3 t -She last worked at	w with Staff C on 12/08/21 at ster facility, but she filled in at imes. the facility on last weekend. drug screening at the facility.				
	4:41pm revealed: -Staff C's hire date -Staff C worked at a she filled in at the fa other times as need -Staff C did not hav facilityHe thought that Sta	another one of his facilities, but acility in June 2021 and a few				
	Refer to interview w 12/08/21 at 4:41pm	vith the Administrator on				
	4:41pm revealed:	dministrator on 12/08/21 at e for ensuring staff had drug re.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
206 FRIENDLY ROAD						
ELIA 1 FAMILY CARE HOME  BURLINGTON, NC 27217						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C992	C992 Continued From page 12		C992			
C992	-He completed drug staff. -He did not know he regarding the test a	g screenings at the facility for e needed information and results. tificate was sufficient to	C992			

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